Complete Summary

GUIDELINE TITLE

Guidelines for the management of pregnancy at 41+0 to 42+0 weeks.

BIBLIOGRAPHIC SOURCE(S)

Clinical Practice Obstetrics Committee, Maternal Fetal Medicine Committee, Delaney M, Roggensack A, Leduc DC, Ballermann C, Biringer A, Delaney M, Dontigny L, Gleason TP, Shek-Yn Lee L, Martel MJ, Morin V, Polsky JN, Rowntree C, Shepherd DJ, Wilson K. Guidelines for the management of pregnancy at 41+0 to 42+0 weeks. J Obstet Gynaecol Can 2008 Sep;30(9):800-10. [77 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Prolonged pregnancy (pregnancy at 41+0 to 42+0 weeks' gestation)

GUIDELINE CATEGORY

Counseling
Management

CLINICAL SPECIALTY

Obstetrics and Gynecology

INTENDED USERS

Health Care Providers
Physicians

GUIDELINE OBJECTIVE(S)

- To provide evidence-based guidelines for the management of pregnancy at 41+0 to 42+0 weeks
- To review the following:
    - Interventions to decrease the incidence of pregnancy beyond 41+0 weeks
    - The evidence for induction of labor versus antenatal surveillance in an uncomplicated pregnancy at 41+0 to 42+0 weeks
    - The role of antenatal fetal surveillance in the uncomplicated pregnancy at 41+0 to 42+0 weeks

TARGET POPULATION

Women with otherwise uncomplicated pregnancies at 41 to 42 weeks' gestation

INTERVENTIONS AND PRACTICES CONSIDERED

1. Accurate pregnancy dating using last menstrual period (LMP) in combination with first and second trimester ultrasounds
2. Adjust delivery date if necessary
3. Sweeping (or stripping) of membranes
4. Labor induction
5. Fetal surveillance in the 41 to 42 week pregnancy

MAJOR OUTCOMES CONSIDERED

- Perinatal mortality
- Frequency of pregnancies continuing after 41 weeks
- Rate of Caesarean section

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The Medline database, the Cochrane Library, and the American College of Obstetricians and Gynecologists and the Royal College of Obstetricians and Gynecologists were searched for English language articles published between 1966 and March 2007, using the following key words: prolonged pregnancy, post-term pregnancy, and postdates pregnancy.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one center or research group.

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations*

A There is good evidence to recommend the clinical preventive action.

B. There is fair evidence to recommend the clinical preventive action.

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.

D. There is fair evidence to recommend against the clinical preventive action.

E. There is good evidence to recommend against the clinical preventive action.

I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline was prepared by the Clinical Practice Obstetrics Committee and reviewed by the Maternal Fetal Medicine Committee and reviewed and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The quality of evidence (I-III) and classification of recommendations (A-E) are defined at the end of the "Major Recommendations."

Interventions to Reduce Pregnancy Duration Beyond 41+0 Weeks

Accurate Pregnancy Dating

1. First trimester ultrasound should be offered, ideally between 11 and 14 weeks, to all women, as it is a more accurate assessment of gestational age than last menstrual period with fewer pregnancies prolonged past 41+0 weeks. **(I-A)**
2. If there is a difference of greater than 5 days between gestational age dated using the last menstrual period and first trimester ultrasound, the estimated date of delivery should be adjusted as per the first trimester ultrasound. **(I-A)**
3. If there is a difference of greater than 10 days between gestational age dated using the last menstrual period and second trimester ultrasound, the estimated date of delivery should be adjusted as per the second trimester ultrasound. **(I-A)**
4. When there has been both a first and second trimester ultrasound, gestational age should be determined by the earliest ultrasound. **(I-A)**

Sweeping of Fetal Membranes

5. Women should be offered the option of membrane sweeping commencing at 38 to 41 weeks, following a discussion of risks and benefits. **(I-A)**

Labour Induction Versus Expectant Management at 41 Weeks

6. Women should be offered induction at 41+0 to 42+0 weeks, as the present evidence reveals a decrease in perinatal mortality without increased risk of Caesarean section. **(I-A)**

Fetal Surveillance in the 41 to 42 Week Pregnancy

7. Antenatal testing used in the monitoring of the 41- to 42-week pregnancy should include at least a non-stress test and an assessment of amniotic fluid volume. **(I-A)**
8. Each obstetrical department should establish guidelines dependent on local resources for scheduling of labour induction. **(I-A)**

Definitions:

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly designed randomized controlled trial.

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Classification of Recommendations**

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I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

**Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of pregnant patients at 41+0 to 42+ 0 weeks

POTENTIAL HARMS

Sweeping of the membranes may cause vaginal bleeding, pain, and discomfort.

QUALIFYING STATEMENTS

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This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Clinical Practice Obstetrics Committee, Maternal Fetal Medicine Committee, Delaney M, Roggensack A, Leduc DC, Ballermann C, Biringer A, Delaney M, Dontigny L, Gleason TP, Shek-Yn Lee L, Martel MJ, Morin V, Polsky JN, Rowntree C, Shepherd DJ, Wilson K. Guidelines for the management of pregnancy at 41+0 to 42+0 weeks. J Obstet Gynaecol Can 2008 Sep;30(9):800-10. [77 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Sep

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Obstetricians and Gynaecologists of Canada

GUIDELINE COMMITTEE

Clinical Practice Obstetrics Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Disclosure statements have been received from all members of the committee.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Society of Obstetricians and Gynaecologists of Canada Web site.

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on March 2, 2009. The information was verified by the guideline developer on March 13, 2009.

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